titioner protested he did not want to be operated on unless it was absolutely necessary, and the doctor did make effort to treat him with a brace which petitioner still wears continuously, and which consisted of a metal and leather harnessing device extending from a point 8 or 10 inches below the belt line to 4 or 5 inches above the belt line. The brace extended around the entire body, and petitioner was advised by the doctor to wear it when he was up on his feet.

After wearing the brace 10 days, in response to the doctor's inquiry, petitioner advised he could not see that it had helped him and again in response to the doctor's inquiry, stated that he had made up his mind that he had suffered enough to get his back corrected, and he would take the operation. The decision to perform the operation was made July 13, 1959, little better than two months after petitioner's injury, and over which entire period of time he had not gotten relief completely from his suffering, particularly in his back, where most of the pain was, and right on down the back of his leg.

A myelogram x-ray examination was made of petitioner, in which an opaque fluid was injected into the spinal canal, and the x-ray studies made.

Petitioner was in the hospital 22 to 23 days following the operation performed on his back, the first 14 of which he was not permitted out of bed. His pain was alleviated for a short period following the operation, but on the 14th or 15th day, when he was gotten out of bed with the assistance of two porters to seek to exercise his legs, the pain returned. Following his stay in the hospital, petitioner was confined to his bed at home about two weeks, and with assistance, gradually began to walk again while wearing the brace as ordered by the doctor. He saw Dr. Oxford some four or five times after the operation, which was as

long as he evidenced a desire to treat him or do something for him.

After the operation, the petitioner could not tell that he was improving at all, and the pain remained in his back after its return, as did the numbness in his leg. He next went to New Orleans and was seen by Dr. Kirgis at Oshner's Clinic. Thereafter, the petitioner inquired of several doctors as to their advice and opinion of Dr. Faludi as a neurosurgeon, and upon being told he was as good a doctor as he could find, the petitioner consulted him. Thereafter, at the request of the respondent, he went to see a Dr. Gosley at the Highland Sanitarium in Shreveport. Under none of the medical men seen by him had the petitioner found any improvement in his condition and the pain had continued ever since the short period of relief following the operation wore off.

After his operation, the petitioner inquired of Dr. Faludi if he thought it would harm him to try and work in a package liquor store owned by one of his friends, that petitioner needed something to do, and the doctor advised him that if he would not pick up anything heavy, he thought it would be all right. After 9 days on this job, the inability of the petitioner to move cases of liquor and beer, because he couldn't stoop over to pick them up, forced him to leave the job.

Even assuming that the petitioner could find a job doing clerical work, his situation is such as that he has to be where he can move around, being unable to sit too long in one place, and experiencing pain if he stands on his feet very long at a time, all of which caused him to just sit down and walk at different intervals. He had no strength in his back to lift any weights of any appreciable amount, and in working as a fireman, even on a diesel engine, there

would be climbing to be done, the bottom of the cab doorway being some 8 feet above the ground and reached by climbing a ladder. Furthermore, the work on the diesel locomotive would require a fireman to make five or six trips through the locomotive and check to see if everything was working all right, and to make such minor repairs as could be done on the road. The seat of the fireman on the locomotive is right over the trucks of the engine, so that in going across rail joints or low places in the tracks, the fireman gets a constant pounding, different to the experience one would have in riding on a passenger car.

Even the experience of riding from Shreveport to the place of trial in Beaumont on the Sunday before had caused the petitioner not to rest any that night, since his back hurt all night long.

Aside from his occupation, the petitioner trained bird dogs and engaged in extensive hunting and fishing trips, which activities he had been forced to abandon, as well as give up his lodge work with the Firemen's Lodge and the Masonic Lodge since attending meetings required him to climb steps which he could not do. Neither has he been able to attend to his yard work which he did before his injuries.

On cross-examination, the petitioner testified that he had never refused an operation at the hands of Dr. Faludi, but did tell him on the last occasion he went to him that he did not want to be operated on any more.

On redirect examination, the petitioner testified as to additional duties required of a fireman, such as assisting the brakeman to use a chain and knuckles carried on the locomotive for that purpose in cases where a draw bar has been pulled, and which work required heavy lifting. Likewise, he gave testimony of one occasion having to use a big

fire extinguisher weighing 100 lbs. to keep grease out of the diesel engines or to keep it from catching fire when they had a hot journal.

The witness *Glenn Hawthorne*, a locomotive fireman for The Kansas City Southern Railway Company, testified he had known the petitioner about 19 years, and that before his injury, he performed his work as well as anyone, but that since his injuries, he has noticed a considerable change in him, in that he didn't seem to be able to get comfortable in any position, and he was continually trying to shift around to a comfortable position; that he had seen him when the petitioner did not know he was being observed, and while he was trying to feed his dogs and experiencing considerable difficulty in trying to get up from a squatting position. The witness had seen the petitioner getting in and out of automobiles and observed that he had considerable difficulty in doing this, as well as in walking up and climbing down steps, even to the extent of moving up sideways and catching on for support in negotiating three steps on the front porch of the witness.

The witness *W. G. Christian*, an employee of The Kansas City Southern Railway Company as a fireman and engineer, testified that he had known the petitioner 18 or 19 years, worked on jobs with him, and that prior to his injuries, he appeared to have no physical limitations that prevented him from doing his work, and that his ability to work was good. Prior to the injuries of petitioner, the witness had hunted and fished with him on frequent occasions, observed him training his dogs, and caring for them. Further, as a member of the same fraternal organizations to which petitioner belonged, he had observed him as a regular attendant before his injuries, and had noticed no difficulty in his movements up some 16 steps to the place of meetings before his injuries.

On seeing the petitioner since his injuries, the witness described his movements as all being very slow, and each step that he took being very cautious and careful. He appeared to have a drag on one side. Particularly did he notice the difficulties of petitioner on a fishing trip when he indicated he had stood all that he could after about an hour or so, and although he had never brought him home from fishing after only an hour before he was hurt, on this occasion he did so, and found he had to catch hold of his hands and help him out of the boat. On the first occasion petitioner attempted to attend a lodge meeting following his injuries, after he came down the steps for refreshments, he had to return home because he was not able to go back up. Following this, the petitioner declined an offer to go to the lodge with the witness again, saying he wouldn't attempt to climb the stairs. Although before the injuries of the petitioner, the witness had been hunting with him on occasions when he'd stay out all day, since his injuries, he would stay out 30 to 45 minutes and have to come in and rest.

The witness *Harry Hatch* was an employee of The Kansas City Southern Railway Company as a fireman and had known the petitioner approximately 17 years. He testified that had petitioner been working during the past year, he would have been assigned for a good portion of the time as an engineer, and that the position for a regular job as fireman or engineer would have been open over this period of time. Before his injuries, petitioner appeared to be sound, in good health and very active, having quite an interest in fishing, which he would pursue over several hours at a time, during which he would give the appearance of being active and physically able. Since the injuries of the petitioner, the witness has noticed limitation in his movements, in that his carriage seems to be impaired, so that he doesn't hold himself as erect as he did before being hurt.

He has observed him with his shoes unlaced, which he had never noticed before in the petitioner, whom he had known to be a very meticulous dresser. On watching petitioner in his back yard when he was going to pet his bird dogs, the witness would observe it was difficult for him, and that he didn't have the freedom of movement he previously had; that he had to stoop a little bit to pet the dogs on the head.

On seeing the petitioner try to get up and down steps, the witness found his movements noticeable, and to be something that just stands out in that they would be comparable to a man who had a stiff leg; that petitioner would put one foot on a step and pull the other one up to it, and put the same foot up on the next step and bring the other one up beside it.

On making an automobile trip with the petitioner to Leesville, Louisiana, the witness noticed that he couldn't get in a comfortable position and that it was necessary for them to stop numerous times for petitioner to get out on the way down and back.

On cross-examination, this witness testified that oftentimes it became necessary for a fireman on a diesel locomotive to do heavy lifting and straining, as exemplified by the necessity to chain up cars, or put a frog on the track. That in the course of such work the general habit is for everyone to pitch in and help, including the fireman and engineer; that the fireman's duties definitely required lifting, since all of the equipment was on the engine, such as knuckles, chains for towing and things.

The witness *Harry Middleton*, a switchman for The Texas & Pacific Railway Company in Shreveport, testified that he had known the petitioner 20 to 25 years, having had a chance to observe his manner of doing his work when the witness worked with him on The Kansas City Southern

Railway Company. On these occasions before the injuries of the petitioner, he seemed to well and actively discharge his work and engaged in other activities, such as hunting, fishing and work about his home. When he first knew the petitioner, he lived across the street from him and observed him in taking care of his bird dogs and his home work quite a lot. Since his injuries, the petitioner had not been the same active man he was before, there being so much difference that it is difficult to describe. Before he was hurt, it was nothing for the petitioner to hunt practically all day, bird hunting, which is pretty hard, and since his injuries, an hour or two hours is an awful long time. As to his fishing activities, he has had to help the petitioner in and out of the boat, which the witness considered showed a lot how badly he was hurt. Prior to his injuries, the petitioner's movements were vigorous, but now they are "draggy and more or less stiff actions," to such extent as that he does not move normally, and when he gets out of a chair, he seems to be in a strain, whereas he never was before he was hurt.

Dr. Heinz K. Faludi testified by way of deposition. A resident of Shreveport, Louisiana, he testified as to having received an M. D. degree from Temple University in 1943; having a rotating internship at Philadelphia General Hospital for one year, and service in the United States Army from 1944 to 1946. While in the army, he took a course in military neuropsychiatry, and during most of his army duty, performed work in neuropsychiatry, ending up a Chief of Neuropsychiatry with the rank of Captain.

On leaving the army, he underwent postgraduate training in neurosurgery in New York, taking a total of five years postgraduate work, four of which were spent in neurological surgery and one in general surgery. The work was done at the V. A. Hospital in the Bronx, New York, in affiliation with the Neurological Institute in New York.

After his postgraduate work, he met the requirements of the American Board for Neurological Surgeons, and went into the practice of neurological surgery in Shreveport, Louisiana. He is a diplomat of the American Board of Neurological Surgery, serves as consultant in neurosurgery at the V. A. Hospital in Shreveport, and is Chief of the Department of Neurology and Neurosurgery of the Confederate Memorial Hospital in Shreveport.

He is also an associate professor of neurosurgery at Louisiana State University, Postgraduate Medical School, member of the American Medical Association, of the Louisiana State Medical Society, and of the Shreveport Medical Society, as well as of the Southern Medical Association. He is on the staff of neurosurgery of the Physicians & Surgeons Hospital, Doctors Hospital, Highland Sanitarium, Willis-Knighton Memorial Sanitarium, and T. E. Schumpert Memorial Sanitarium, all of Shreveport, Louisiana. After testifying that neurosurgery is a specialty of medicine which is concerned with the diagnosis and treatment of disease or injuries to the nervous system, which would include injuries to the head and brain, to the spine or the spinal cord and to the peripheral nerves, the doctor testified that he had occasion to see and treat Homer R. Simmons first on January 27, 1960. The patient was referred to him by Dr. E. W. Harris, Sr., because of persistent low back and leg complaints. The examination of Dr. Faludi developed that the pain was specifically located in the low back, and of a nature as described by the patient as if something were shoved up his back. The pain was described as radiating to the right posterior thigh, and in the sitting position, pain would be experienced in the posterior lateral calf on the right and over the lateral right foot. Complaint was made of pain in the left thigh occasionally, but usually not as severe as on the right. The patient had observed that the right foot tends to swell when moving around or when sitting in one po-

sition for a long time, which condition was described as a "puffed up" feeling in the right foot and the toes and the ball of the foot. Complaint was made by the patient of occasional pain in the left arm and in the back of the neck, and of both of his hands tending to fall asleep at times.

A description was given by the patient of his injuries of May 10, 1959, his actions following his injury, the consultation with Dr. Rushing, and treatments received from the various physicians who had seen him, all leading up to the operation of July 14, 1959, following the taking and interpretation of myelogram. Likewise, the postoperative condition of the patient was narrated by him to Dr. Faludi, as well as his past medical history of accidental injury in 1943, in the area of his right hip, followed by about six days' disability, and a right inguinal hernia operation in 1954, as well as treatment for peptic ulcers off and on for the past 18 years.

The actual neurological examination of the patient made by Dr. Faludi disclosed that the patient was a 46-year-old white male, appearing to be cooperative and pleasant during the examination. He was of the asthenic habitus, or skinny type, of somewhat slender type and appeared to be in acute distress. When he walked, it seemed that he walked with a severe limp and he tended to protect his right leg. Examination of the head and neck were negative, the lungs seemed to be normal, heart examination negative, blood pressure 110 80, which is normal. The examination of abdomen was essentially negative. On examination of the low back, Dr. Faludi found that the patient had an incisional scar in midline extending from about L3 to S1, which appeared to have well healed. There was still tenderness over the lumbosacral region of the incision. This region was described as where the lumbar spine and the sacrum join up, and where the greatest bend is in the low back

In a supine position, the patient would be on his back and lying flat on the examining table, and at which time he tended to keep his right leg flexed, which usually is an indication that it is painful when he stretches it. There was a slight weakness in the right calf musculature and there was some atrophy of the right calf or wasting away. Measurements disclosed 32 cm. in circumference for the right calf, and 34-1/2 cm. in circumference for the left calf, showing a difference of about one inch, which is significant. There was slight atrophy involving the medial gluteal musculature on the right. It appeared that the lumbar lordosis was reduced, which means the usual curvature of the low back that is usually a concavity presented an appearance of being somewhat reduced. Motions of the lumbar spine were severely restricted and were estimated to be about 30% of normal in flexion, 30% of normal in extension, and 30% of normal in right and left bending. There was tenderness over the lumbosacral joint, there was also tenderness over the right medium gluteal muscle. The supra patella reflex was hypoactive and symmetrical bilaterally, the patella reflex was active and symmetrical bilaterally, the Achilles and posterior tibial reflex were absent bilaterally. The doctor found a central diminution over the fifth lumbar and first sacral dermatone on the right, but it seemed to him that there was some psychological overlay involving neighbor dermatones as well.

The psychological overlay was explained by description of the examination for sensations over certain nerve areas in the body which are known to be supplied by certain nerves. When a patient states that he has a sensory diminution over such an area, and if it coincides with the anatomical distribution of such a nerve, then the doctors designate that this sensory diminution is over a certain nerve area. In the particular patient it was approximately over the area of the fifth lumbar and first sacral nerve root on the right

side, but the borderlines were not completely distinct, and it seemed to the doctor that the patient was a little generalizing in saying that it was a little higher and a little wider and so on, rather than that it was distinctly localized to this area. It was, however, sufficiently well localized that the doctor felt it may have had some significance.

The straight leg-raising test was performed and could be done to about 60° off the horizontal. It is performed by the patient being placed on his back, and asked to keep the leg straight, and the leg is then raised off the horizontal and the particular patient could raise it to about 60°. When raising the leg high, he complained of sciatic pain. Ordinarily, a patient can raise the leg up to 80° or 90° and should not have sciatic pain. This was considered a slightly positive La Segue test, which indicates some irritation to the sciatic nerve or its components. When the same test was performed on the left side, the leg could be raised about 70° and when it was raised higher, gave an increase in low back pain on the right side but no sciatic pain. The hip flexion test gave also an increase in low back pain. The hip extension test gave slight increase in the low back pain. The hip extension test gave slight increase in the right lower back pain. The doctor next described the distribution of nerves from the brain which end in the low back region, and from which point another neuron or another nerve would take over, and then go to the lower extremities. He described a center in the low back that supplies the lower extremities, and the location of the spinal cord inside the backbone, which could be compared to a cable that carried lots of wires. Out of the spinal cord come the nerve roots, the doctor testified, which would be the wires coming out of the cable; and if there is any damage to the backbone or the structures around the backbone that may push against that cable, or the wires emerging from that cable, then this damage may be felt in the distribution

of these wires, or in our human body, the nerves as they project themselves in the lower extremities.

The examination performed by the doctor had as its purpose ascertaining whether there was some involvement of the cables and nerve roots, and the weakness in the right calf musculature and atrophy therein would indicate there was some involvement of the nerves supplying those muscles. And in the calf musculature, it is foremost L5 nerve root and S1 nerve root which have to be considered. The doctor testified to a distinction between atrophy arising out of disuse by saying that if the atrophy was of some significant degree, it was usually the result of damage of nerves which supply the muscle. If a muscle is without nerve supply, it will show shrinkage or atrophy, which is the significant in the marked type of atrophy. The atrophy of disuse usually comes from a very definite disuse such as a limb being in a cast, and it is usually not as marked as the atrophy that ensues when the nerves to the muscle are damaged.

The reduction of the normal lordosis or lumbar curve usually indicates some irritation to the muscles giving them some spasms, or sometimes the patient splints against a painful motion by holding the back rigid and that will give some reduction of the lordosis.

The usual lumbar spine, the doctor testified, has great flexibility and can be moved well from forward to backwards and somewhat less well from side to side. If these motions are restricted, it would usually indicate that there is some pathology in the back preventing the patient from using the back to full extent. This may be due to actual pathology, contravening this motion, or it may be due to muscle spasm, or it may be due to pain that the patient does not use the back in a case like that.

The sensory diminution over the dermatone which the doctor described had significance in that if there is pressure against nerves, there will be some sensory diminution if it is long enough and severe enough and it usually helps in the diagnosis to determine which nerve is involved. The leg-raising test is a particularly good test to check on irritation of the sciatic nerve or the components of the sciatic nerve.

The doctor gave as his opinion that the patient most likely had a radiculitis involving the L5 and S1 nerve root on the right. Radiculitis means involvement of the nerve root of L5 and S1 on the right, and with the history that the doctor had obtained, that this patient had a previous operation, it was the doctor's feeling that most likely the radiculitis was secondary to the previous disc removal and operation, and the doctor felt that there were residuals of the previous pathology which supposedly had been removed.

He recommended that the patient continue with conservative treatment and then he said only if completely unable to give the patient relief with conservative treatment one should consider a re-exploration in order to free the patient of the scar formation and possibly to perform a posterior rhizotomy—which is cutting the pain fibers of these nerves—if it were found that the root was irreparably damaged, in order to give the patient relief. On a later visit, the doctor did recommend a repeat myelogram, and on March 7, 1960, the doctor hospitalized the patient at Schumpert Sanitarium, and a myelogram was performed at that time (S.F. 182-183). The patient was seen again on May 16 and on June 15, 1960, at which times he would say that in essence, the complaints of the patient were quite the same. On this visit, the patient was emotionally upset about the death of his mother-in-law which had upset his wife, and the whole family situation was said by him to be

in an uproar, which the doctor concluded was an additional factor in the particular visit. At this time, medicines were recommended and a hydrocollator, which is a device which supplies steam to an area. Again the doctor recommended conservative treatment.

On the examination on June 15, the complaints of the patient were of numbness of the right leg up to the knee, and at that time, the doctor felt that inasmuch as the patient's pain seemed to have not really responded well to conservative treatment, that one should very much consider a reoperation. The doctor also stated to the patient that he could not make any definite promises as to the success of such a reoperation inasmuch as the doctor did not know what state these nerve roots would be in when he found them, but felt that if the patient's pain was very severe, that he should have such a re-exploration. At the time, the patient stated that he would think over the matter of having the re-exploration, and on July 18, 1960, notified the doctor's office by telephone that he had decided against having surgery performed at that time.

Reverting to the myelogram performed March 7, 1960, the purpose of the test was described by the doctor as an additional help in diagnosis, and in itself is a test in which the doctors perform a spinal puncture, which is a needle puncture of the spinal cord, and then examine the spinal fluid, test the manometric situation, which means seeing what the spinal fluid flow is like, and then instill some medicine into the spinal canal which medicine has the property that it shows on x-ray, and then the doctors take x-ray pictures, make fluoroscopic studies and see what the spinal canal looks like.

Following a description of the structure of the spinal canal and nerves, which are normally surrounded by spinal fluid and covered by different membranes, along with ar-

teries and veins and supporting structures in the spinal cord, the doctor testified that if something else should be in the canal pressing or pushing into it, you would have an abnormality. Such a pressure may be apt to cause the nerve dsturbance which he described in the petitioner. On making the spinal puncture, it was found that the fluid was clear and the initial pressure of the same was 140 mm. which would be considered normal; the manometric tests performed on the spinal fluid were negative and there was no sign of obstruction of the spinal fluid flow. When the doctor introduced the pantopaque (a fluid opaque to x-ray), which is the medicine used to visualize the area, the doctor found that the myelogram showed a questionable defect at the level of L4. This would be the fourth lumbar vertebra and from the appearance of the x-ray defect, it was felt that it was more likely that the patient had an old scar formation around the nerve root rather than a new herniation of a disc, and it was the doctor's feeling that the patient apparently had residuals from his previous disc pathology and that he had formed scar formation from pressing the lumbar nerve roots, particularly the L5 nerve root, which is the one that runs at the L4 vertebra on the right side. Scar tissue may form after injuries or following surgery.

The last visit the patient made to see the doctor was on September 27, 1960, at which time the doctor found no significant changes in him. The patient reported that he had good and bad days, or that there was some variation in his feelings, but the doctor testified that is what was found with most any condition, and that the patient still has essentially the pain in the right lower back and in the right posterior leg. He compla ned of some numbness in the right posterior lateral foreleg and foot and of that he had complained previously. Before the last examination, the patient had asked the doctor's permission as to whether he should or should

not take a job, and the doctor had encouraged him and told him that he should try to take a light job and see what he could do with it, and then on the last visit, the patient informed the doctor that he had taken a job with a package liquor store company, and that he worked there, but that the work entailed the lifting of cases of beer and that he was unable to do it, and that he had had to quit his work after about 9 days. That was part of the history the doctor obtained at the last visit. The findings were very much the same, and the doctor's conclusion was that the patient still had the evidence of showing some nerve root involvement of L5 root and maybe some of the S1 root, mostly on the right.

The doctor gave it as his opinion that the patient in his present condition was not able to engage in work which required sustained heavy lifting or stooping, bending and that sort of thing, heavy manual labor. Next, he described the nature of the re-exploration of the L4 region and the L5 region as being an operation as would be designed to free the nerve roots of scar tissues or any other pressures that might be found on them. If he should find that the nerve root was irreparably damaged on such an operation, and that it looked real bad, then he would feel that in his judgment, he should have a rhizotomy, which is sacrificing the part of the nerve root that conducts pain, by cutting it, and he would feel that such a rhizotomy would be indicated to give him pain relief, at the expense of feeling numb in the left leg after it.

On cross-examination, the doctor testified he had not had the benefit of seeing myelogram studies or reports of a myelogram made prior to the operation the patient had already had, and that he would not know whether there was a herniated disc there or not, except from the history. The doctor gave as his diagnosis that the patient had a radiculit s,

meaning an involvement of the nerve roots of L5 and S1 on the right side, and this was based on many findings, and that most likely the radiculitis or nerve root involvement was secondary to residuals from previous pathology or operation. It can very often happen, the doctor testified, that patients who have had nerve root pressure for some length of time and undergo an operation, will never completely recover from that nerve root pressure and will remain to show a radiculitis. This will not infrequently happen, it may happen also secondary to the operation itself.

The doctor testified that there would be a reasonable chance of relief in the case from another operation, but a lot depended on the findings. He testified that even in the very best of hands, if a nerve is already badly damaged, then even if one frees this nerve completely of scars or pressure or anything that may interfere with it, it may not completely recover. That the doctor thought that in a case like that of the patient's, where the patient had had so many complaints and where they have yielded so very little to treatment, that he would think an operation would stand a chance, probably better than an even chance, to offer him some relief.

The doctor testified that the operation was one that was acceptable and recommended by a neurosurgeon as a measure for relief in this type of situation and that the disc operations themselves and also nerve root operations like rhizotomies and so on are some of the more frequent operations in the repertoire of a neurosurgeon. He opined that the individual case had to be judged by the findings really, and that one could not talk about statistics when it comes to such individual cases, but that he had been successful in most of the cases in giving relief.

The operation was described as one to remove the scar tissue surgically and thereby eliminate and take away the

pressure element, a procedure both anatomically, pathologically and mechanically possible, and one frequently done by neurosurgeons. A second measure was described whereby after evaluation of the situation and having looked at it, upon operation the surgeon, if he felt there was no feasible way to remove the scar tissue, could perform a rhizotomy; which probably could be done at the same operation. The rhizotomy, the doctor would say, would give the patient a fairly good chance to get relief, particularly if the pain was well localized; that it is a very successful operation if the pain is merely confined to one or two nerve roots, but if it is a more widespread pain, the operation is less successful. The doctor concluded that he thought the pain was fairly well localized, and that the operation would stand a fairly good chance for success, and that the operation had been recommended to this patient for the reason that he had so badly failed to respond to other treatment. The patient is not functioning well as it is, and the doctor felt that at worst, he would probably not be worse than he is now, and at best, maybe much better, even to the extent of procuring enough relief to engage in remunerative employment, assuming the operation is successful.

The operation of a laminectomy and a rhizotomy would be the more extensive type and usually required 10 days to two weeks in the hospital, and then a convalescent period of about one month at home. After that period, assuming that the operation is successful, it would depend on what type of work a person would do as to how soon he could return to it. A white collar or desk worker might be allowed to go back after the short period of convalescence, but if a person was doing more involved work, more physically involved work, the doctors would say to wait another three months perhaps. If a person performed heavy work, the doctors might say that he could do light work, let us

say for a period of six months, and then try on harder work after that. That is if the operation is completely successful, but there is room, of course, for the possibility that it is not completely successful, then these figures would vary.

The doctor gave it as his opinion that he thought the patient would stand a reasonably good chance of being improved and freed of some of his pain, but he was not quite sure that he would definitely be able to go to heavy manual labor. His opinion was that the patient should probably be able to do moderate labor fairly well. That he could do moderate work which would not necessarily be white collar work but not necessarily be heavy work; that one would really have to go into specifics to be able to make a better answer.

On redirect examination, Dr. Faludi testified that from his observation of the patient over a period of several months, he felt that his condition was stationary and that he doubted very much that with conservative treatment he would substantially change. Turning to the question of disc operations, the doctor testified that statistics vary with different clinics that report them; that his own statistics in disc surgery about he would say that perhaps at least 70% are very substantially improved or even part of them cured of the pain. This would leave about 20% of cases that would be unimproved, and the doctor would say that there may be 10% who actually may be worse after disc surgery. The statistics were described as being overall, as he looked at the question in his own experience, and with the experience of others with whom he had been associated, but that the statistics do not pertain to one particular patient; because if the doctor would get, for instance, an acute disc herniation in a young individual, very localized to one nerve root, he would say that his chances are 95% good that he would do very well. But when you take long-

standing cases, neglected cases, old people and all the bad risk cases together with the good ones, then you get statistics like that. The doctor testified he believed now that the petitioner would not be in the good risk group any more, but would probably be somewhere in the poor risk group.

On specific hypotheses, the doctor testified that stooping alone and bending alone very often could be done by patients with the disc operation, but by use of the knee action rather than with the back action, and that the doctors recommended often in such type of case that the patient should not stoop and bend his back, but stoop by bending his knees and get down. If the work required lifting at the same time, the doctor would feel that heavy lifting, let us say, 50 lbs. or more, would be probably contra-indicated in a patient of this type. Moderate lifting with the help of knee action should be possible, perhaps if the operation were successful, maybe not at the very first, but maybe after six months' period of time or so.

The doctor would not, as a physician, feel that the patient should do work such as climbing a 12 ft. ladder four times a day, 6 to 12 times a day; that he would probably try to get the patient assigned to some other type of work; that he would feel it would be somewhat strenuous for him.

The doctor gave it as his opinion that $1,500 would be quite an adequate amount for the contemplated operation and its incidents, except for possibly a very severe complication that would not be foreseen.

On re-cross-examination, the doctor testified in response to an hypothetical question that if the operation would fulfill all the hopes and expectations that the doctors would have of it, the patient may be able to do work that did not involve heavy lifting but did involve riding on a train, getting on and off an engine, giving signals and using the hands and arms, and that sort of activity that did not in-

clude the lifting of packages or heavy items, objects of 50, 60 or 70 lbs. and work of a nature that was not a lifting job but rather a job of presence, and perhaps giving of signals on the railroad and so on, which involved the use of the shoulders and the hands rather than the lifting processes, such as a laborer, but that if the operation should fall short of all the hopes and expectations for it, the patient might fall short of doing that type of work.

Charlie H. Flowers testified by way of deposition that he was a representative salesman of American General Life Insurance Company and as such, familiar with the rate book used by it that quoted rates for different types of life insurance and annujties. He properly identified the Commissioners' 1941 Standard Ordinary Table of Mortality which was introduced in evidence, as identified in his rate book, and also the table from the rate book showing the costs of various annuities, including the single premium immediate life annuity, that was likewise introduced in evidence.

From the table, he gave testimony that the cost of a single premium immediate life annuity to pay the sum of varying amounts per month to a person 48 years of age over his life expectancy would be as follows:

For $625.00 monthly, the single premium would be $145,144.37.

For $800.00 monthly, the single premium annuity would be the sum of $185,784.00.

From the same table it is mathematically demonstrable that to provide a monthly income of $750.00 per month, the single premium for an immediate life annuity would be $174,173.25. The Commissioners' Standard Table demonstrated that a person 48 years of age had a life expectancy of 22.88 years.

There was no rule for involuntary retirement at age 65 in force on the railway of the respondent, as evidenced by the testimony of *Joseph Corrigan, Jr.*, engineer on the run with the petitioner when he was injured, to the effect that he was 69 years of age, and had been a locomotive engineer since 1916.

Mrs. Homer Simmons, wife of the petitioner, testified that she had married him in 1936. Further, that Mr. Simmons had engaged in oil field work and other work requiring lifting and carrying until he began railroad work. She stated that he had been regularly employed until he was hurt in May of 1959. In addition to his labors, he performed services around the house, such as moving furniture when it was desired to be moved, getting on the roof and cleaning out gutters, going up through a closet to the attic to turn the heating unit on and off, when seasons required, all of the yard work, including the planting of grass, flowers and shrubs.

She reiterated the facts concerning the petitioner's enjoyment of fishing and hunting prior to his injuries, and his engaging in such sport on every opportunity that he could in the course of which he actually trained dogs, and even after giving some to friends, would keep several at a time.

She parked at the side of the Union Station to meet him following his injuries, at which place there were slight steps that had to be used in coming down to the parking area, and she observed that the petitioner when he arrived hardly manage to get down these which alarmed her. He was helped in the car by Mrs. Simmons, and the next morning, a call was made to see if he could see a doctor. This could not be done the first day, even though petitioner waited at the doctor's office until he was worn out, and indeed it was the third day after he was injured that he finally saw a doctor.

Prior to seeing the doctor, he had been given home treatment, particularly on the night that he arrived, but he did not rest that night. On seeing a doctor, hospitalization was suggested, and he was given heat treatment, to perform which the Simmonses purchased a heating pad and Mrs. Simmons would massage his back. The petitioner was spending all of the time in the house save when he made trips to the doctor's office, and was not able to be up. He made complaints of the lower part of his back and right leg in particular.

The petitioner was taken to the hospital in a car by the witness and walked in with her assistance. On the Monday that the petitioner was discharged from the hospital, the witness in response to a telephone call went to his bedside and found him sitting on the side of the bed, following which she helped dress him. With the assistance of a man in the area, the witness got the petitioner down a few steps from the door of the hospital, and upon reaching home, was put to bed. He was still making complaints of present pain in the same area, his back and leg. On up until his entry in the hospital, about the 13th or 14th of July these complaints continued, particularly when he would stay in one position too long or try to get up out of the chair, or go down steps, not stairs, because he couldn't.

Following the operation, the witness saw the scar on petitioner which was approximately 6 or 7 inches, beginning at the waistline and extending below, and in approximately the center of the back. Another patient who had received a disc operation after that of Mr. Simmons was situated in the same room with him, and had gone home before the petitioner was permitted to sit up some three weeks following his operation.

The petitioner was in the hospital about a week after he first sat up following the operation, and thereafter, on

the doctor's decision, returned to his home where he remained in bed several weeks. His complaints of pain in the lower portion of his back and right leg continued over this period, and indeed, had never stopped completely at the time of trial.

After the petitioner began to get up and get around the house, he had some limitation of motion or movement, and over the last six or eight months preceding the trial the witness had seen no appreciable change in the way petitioner got about. He continued to receive treatment at home in the nature of the use of a heat pad, liniment and the rubbing of his back and leg. On occasions when the petitioner would take some kind of a trip in a car, or get out and walk around, the witness would notice a great deal of change in that he would not rest much at night after such trips.

The petitioner was recalled to the stand by the respondent, and asked if he had made any effort to return to work for the railroad in the last three or four months, to which he replied he had not.

On examination by his counsel, petitioner testified that he had made an effort to resume his duties since he was injured; that he had told Mr. Rymand, of the legal department of The Kansas City Southern Railway that he was willing to return to work, if the doctor would give petitioner a letter saying he was able to resume all responsibilities of a fireman and locomotive engineer; and if Rymand would give petitioner a letter saying that he would accept the doctor's decision and be responsible for the condition of petitioner, which Mr. Rymand declined to do. This occurred shortly before the petitioner employed counsel around June 1, 1960.